# The Shoe Clinic

Suitable shoes for patients with arthritis @ diabetes

## STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

Program Objective is to transfer forces form high to low pressure areas, giving protection for the diabetic foot, absorb shock and reduce shearing, modify weight transfer patterns, limit motion or painful joints, facilitate ambulating and maximize comfort.

To get started, have your Doctor complete ALL of this form.

Patient's Name_____

Phone_____DOB_____

Address_____

City_____State_____Zip_____

Medicare #_____Supplemental_____

Rx *Extra Depth Shoes and Multi-Density Inserts*

Physician Managing Comprehensive Care of the Above Patient's Diabetic Condition

I certify that the following statements are true

1. This patient has diabetes mellitus ☐ insulin ☐ non-insulin
2. I am treating this patient under a comprehensive plan of care for his/her diabetes
3. This patient has ONE OR MORE of the following conditions which makes this patient eligible for this program: (Check all that apply)
   - ☐ History of partial or complete amputation of the foot
   - ☐ History of previous foot ulceration
   - ☐ History of pre-ulcerative callus
   - ☐ Peripheral neuopathy with evidence of callus formation
   - ☐ Foot deformity (bunions, hammer toes, etc.)
   - ☐ Poor circulation

ICD-10 diagnosis codes _____

Physician's Signature_____MD/DO Date:____/____/____

Physician's Name_____

Address_____City_____State_____Zip_____

UPIN_____ N.P.I.# _____Phone(____)____-_____

BRING THIS COMPLETED FORM TO OUR STORE ( NO FAXES PLEASE)

6871 Quail Hill Pkwy. Irvine, CA 92603 . (949) 559-1150 Fax (949) 559-1332

# STANDARD WRITTEN ORDER

THE SHOE CLINIC, INC.
6871 Quail Hill Pkwy
Irvine, CA 92603
(949) 559-1150
(949) 559-1332 – Fax

Today's Date:

Patient Name and Address

DOB: / /19

FAX TO: : Date of Face-to-Face Completion
FAX NO: :



Dear Physician:

Please review the details of this written order for the above named patient. Make corrections when necessary, response.

Diagnoses and codes specific for functional conditions requiring durable medical equipment:

1) : 2)
3) : 4)

Length of need: _____ permanent or _____ months

| ITEM DESCRIPTION | QUANTITY | UOM | HCPCS | List | Allowed |
|---|---|---|---|---|---|
| Diab shoe for density insert | 2 | EA | A5500 | 162.52 | 147.74 |
| Multi den insert direct form | 3 | EA | A5512 | 99.43 | 90.39 |
| Multi den insert direct form | 3 | EA | A5512 | 99.43 | 90.29 |
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I, undersigned, certify that the above prescribed durable medical equipment and supplies are medically necessary for this patient in order for this patient to perform activities of daily living.

| Prescribing Physician's Signature | License Number | NPI Number | Date Signed |
|---|---|---|---|
| | | | |